

Keynote address

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In my former position as a surgeon in Philadelphia, I was always a close friend of the osteopathic specialists and pioneered in the training of osteopathic medical students and residents in pediatric surgery. Had I not left Philadelphia, I might have been the first to turn out a full-fledged osteopathic pediatric surgeon. I would have liked that.

But training is not enough. We only merit the term "professional" if we put that training to work in the service of improved health and well-being for the American people. In this area, the members of the osteopathic specialties continue to earn the right to be called "professional" and merit the high regard of all American citizens.

This is not an easy thing to do, particularly in a period when this country is under intense economic pressure. Our colleagues and patients have had to negotiate their way through an economic landscape that is riddled with potholes: inflation, scarcity, imbalance, and inequity. As the surgeon-in-chief of Children's Hospital in Philadelphia, I saw the cost of care rise beyond our control. Materials, energy and fuel, personnel, maintenance, and medication—all the thousands of items and services that combine to make up what we call medical care—continue to rise. Yet, all persons involved in health and medical care have managed

to maintain a high level of quality and productivity. But the question that confronts us is "How long can we continue to do that?"

This is the question that President Reagan has posed to the nation since the day he took office. He described the situation in a recent speech: "Eight months ago . . . few of us could keep our heads above the rising inflation rate. Our economy was sinking and taking most Americans with it." For many of us in medicine, whether practitioner, trustee, or administrator of an institution of care, the president's description could be called an understatement. The president's economic recovery program was launched on inauguration day and it has been a top priority for the government ever since, and I believe it has finally penetrated the consciousness of most Americans and has become *their* top priority as well.

It used to be that, if you asked a physician to list the major influences in contemporary medicine, his or her response would tend to include things like the breaking of the genetic code, the development of the CAT scanner, the possibility of a physician surplus or a nursing shortage. However, I think most of us have broken out of that cocoon. We would now put inflation at the head of the list. Next would come those things that we have to do as a society to bring inflation under control and stabilize our economy.

Clearly, one of the major influences on the inflation spiral has been the federal government it-

self. In 1980 this country spent, from all sources, a total of \$247 billion for health services, personnel, facilities, materials, and research. Of that total, some \$57 billion or 23% was spent by the federal government. This has been a rising figure, giving government extraordinary interest and leverage in the health marketplace. The purchasing demands of government have skewed the costs of goods and services as well as contributed to their overall rise. It is the devastating effect of federal purchasing to which the White House, the Department of Health and Human Services, and Congress have addressed themselves this year.

You have read the newspapers, watched television, and read the journals and newsletters serving health. You know the kind of effort that has been expended so far to cool down the growth of the federal health budget. It has been nothing short of extraordinary and it has been very, very difficult from almost every perspective.

We have had to take a hard look at every federally supported health program and ask some tough questions about it.

- What is its purpose?
- Is that purpose being fulfilled?
- To what extent is it being fulfilled? Could it be more effective? Would that be a good thing?
- Is it something that government intrinsically does well or could some other sector of society do the job better?
- What is its impact on the rest of health and medical care,

whether federally supported or not?

The questions are tough and the answers have not come easily for several reasons. Some people feel that the asking of such questions is a challenge to the motivation of those persons who fought for the programs in the first place. That is understandable, but it is also not relevant. The motives are unquestioned.

I think it is generally accepted by everyone in Washington and elsewhere around the country that the great expansion of federal health and social services sprang from decent impulses. The kind of impulses that have been the mark of our society among all other societies on this planet. We see a problem, people in need, and we want to help. We crank up a new tool—federal aid—and feel reasonably secure in our compassionate response to the need. Unfortunately, we did a great deal of cranking up over the past two decades. Last year there were nearly 500 separate or categorical aid programs funded by the federal government to deal with virtually every known medical and social ill. There were additional programs that had become law, but Congress has not yet gotten around to funding them.

Over the past eight months, these programs, along with hundreds of others in the executive branch and in many independent agencies were scrutinized very closely. Several conclusions were reached that seem to fit together into a coherent, national policy for the support of health and medical care in this country. It is different from past policy. It has to be to meet the total needs of this country. Let me briefly sketch out a couple of these conclusions.

The government has been spending a lot of money on activities that really cannot be bought. The prime example is professional standards. You are

all familiar with the history of Professional Standard Review Organizations (PSROs), and a checkered history it has been at that. I do not believe that a wad of federal money can insure the public that physicians or anyone else will abide by high professional standards. That is the job of the professions themselves. You cannot make them stick by publishing them in the *Federal Register*.

The setting of standards and the enforcement of those standards of practice are the responsibilities of the professions. Therefore, this administration intends to phase out federally supported PSROs. The PSRO is a good idea, but not for Washington to impose on the physicians of America. We as physicians must voluntarily enforce those standards, monitor our performance, and police ourselves with maximum effort and integrity. The dividends will be high for us and our patients.

The government finances and regulates other activities of which it has very little direct knowledge and experience. A case in point is health planning. We know that planning can be a complex activity. If done well, it will take into account all the variables in a state, county, or municipality and adjust for them. However this is a big, diverse nation with a multitude of such variables. The federal government made a valiant effort to construct a national program of health planning with a regulatory and administrative structure broad enough to take all those state and local variables into account. The program generated a blizzard of paper and very little evidence that such federal direction really helped state and local planners get a handle on health care and health costs. In some instances, it simply got in the way.

This kind of program is best left to the states to initiate, fund, and control. The federal supports are being phased out over a two-year period. By then,

the planning agencies that are doing a good job and making a positive contribution will no doubt continue to receive state and/or local support. Those that do not will gradually disappear. The desire or intuition of a distant federal agency will no longer matter.

That leads quite naturally into another conclusion about the structure of federal support for health; a conclusion that is also part of a much larger issue in American society.

Many activities ought to be continued, but the authority for conducting them should be vested in the states and no longer in the federal government. This was not conceived overnight. Rather, for several years there has been a general uneasiness about the degree to which the balance of power in our democracy has shifted so dramatically away from state government and toward the federal government.

The president set about to restore the balance of power between the states and the federal government, and those of us in public health have made our contribution to that effort. The mechanism chosen by the president to accomplish this is the block grant, a consolidation of several similar federal programs that is transferred to the states, along with a consolidation of the federal funds behind those programs. Authority to run those programs, to adjust the allocation of resources among the programs within the block, and to set program priorities is transferred to the state.

The president's original proposal last March would have consolidated the authorities and funds for 25 public health programs into two block grants to the states and territories. After many months of discussion, Congress produced four block grants that consolidate, in different fashion, 22 categorical public health grant-in-aid programs. While I am disappointed in the change from the presi-

dent's proposal, I am nevertheless heartened by the fact that the idea of block grants to the states has been accepted by Congress and enacted into law. I am happy to report that all states have applied for the maternal and child health block grant and it looks as though they all will apply for the health services and prevention block grant.

There had been much talk about the willingness of the states to accept responsibility for these programs. The implication was that the states were somehow aware of their own limitations, that they might elect to turn back the clock of social progress, and that their level of professionalism and dedication was somehow of a lesser order than the level among federal personnel. Such implications are completely groundless and totally unfair. Of course, there are differences of style, approach, and capacity among the states, just as there are among federal agencies. Those differences are precisely what federalism is all about: different local, state, and regional approaches to the solutions of common problems.

The president's program of "New Federalism" is especially important for health and medical care, where state, county, and municipal agencies, both public and private, are on the front line of service. It has been the intention of this administration that state and local government, and the private sector the professional associations, the voluntary organizations, charitable groups, and foundations would become involved to a higher degree than may now be the case, and would directly participate in the shaping and conduct of health and medical care in the United States.

There has always been a measure of participation, sometimes quite high and quite visible and other times rather muted. But the executive branch of the federal government has the capacity to shield itself to avoid mak-

ing the kind of contributions other levels of government or the private sector make. That has now changed. Under the president's leadership and with the presence of former Senator Richard Schweiker as the secretary of health and human services, I believe that the executive branch of the federal government has a real opportunity to regain its own sense of balance and see how it can make its own unique contribution to the conduct of public business, and do it as a partner, rather than as the master of the situation.

One of the best examples of this is the campaign, launched this summer, called "Healthy Mothers, Healthy Babies." It is based on the data generated by the National Center for Health Statistics. Those data show a continuing high risk of infant mortality or morbidity among disadvantaged and minority women and teenage girls who give birth. The cost to those women, to their families, to the surviving infants, and to society as a whole is enormous, in both dollars and psychosocial terms. While the public health service has been the catalyst for this campaign, it remains a partner with over a dozen major national organizations representing health professions, educators, and concerned lay persons. The cosponsors of the organizational conference last month included the American College of Obstetricians and Gynecologists, the American Academy of Pediatrics, the American Nurses Association, Parent-Teachers Association, and the March of Dimes which played a major leadership role in this campaign thus far and has pledged to continue it. The partner idea works and people benefit.

Finally, in this overview of national health policy as it is being redefined in Washington today, let me say that there are some things that the federal government does well and should continue to do. The first activity that usually comes to mind in this

regard is support for biomedical and behavioral research. This country can be proud of its exceptional research enterprise at the federal level: The National Institutes of Health, of Mental Health, of Drug Abuse, and of Alcohol Abuse and Alcoholism; the National Science Foundation, the epidemiological and bench research in the Centers for Disease Control and the Food and Drug Administration; and the vast research enterprise that is supported by federal funds outside government in our universities, medical centers, foundations, private laboratories, and among expert investigators overseas.

We cannot let this outstanding research capacity wither or be denied its essential nourishment of interest and dollars. Within austere budgetary periods such as the one we are now in, it may be necessary to set some priorities for the investment of scarce dollars, but to risk the continued vitality of our research capability would be to risk the very foundation of medical care itself. How we practice and how and why we make the judgments we do in our specialties reflects the knowledge that has been developed and transmitted by the research community. Clearly this is a federal priority, a responsibility to be exercised at the national level.

We also look to the federal government to have the expertise and the mobility to attack a variety of health emergencies or tasks that reflect national, not regional or state, needs. We in the public health service are especially proud of the way we have carried out our professional responsibilities in dealing

with the eruption of Mount St. Helen and the health risks of that natural event; the environmental challenge of the Love Canal area and similar areas around the country that have been put at risk by toxic waste discharges; and the teamwork required to protect the residents in the area of the Three Mile Island nuclear power plant. These are just a few of many examples in which the federal government is the agent of choice to handle a sudden threat to public health. Of quite a different nature, but no less threatening, are the sudden appearances of unfamiliar disease conditions: toxic shock syndrome, Legionnaire's disease, dengue fever, and others. This also requires mobility, instant expertise, and legal as well as medical authority.

In most of those instances, the first men and women to arrive at the scene and begin the processes of identifying the nature of the event, caring for the people involved, and working with local and state authorities were the members of the uniformed commissioned corps of the US Public Health Service. There has been much discussion lately about the establishment of a rapid deployment force for the American military, an important part of our total American defense effort. But I would suggest that there is, in the service of civilian health needs, a rapid deployment force that has been doing an effective job for more than a century—the US Public Health Service Commissioned Corps.

For many years the medical profession has tried to hold back the relentless growth of government. The profession argued that it could best handle the

health needs of our citizens, particularly when in partnership with public and private state and local agencies. Because those persons and groups closest to the patient were the most qualified to handle his needs. That has been a rallying cry for quite a while. Well, the physicians' turn has finally come around. I am reminded of a remark attributed to Alfonso X, King of Spain, 700 years ago. He was known as Alfonso the Learned and he apparently took that title seriously. He supposedly once said, "Had I been present at the creation, I would have given some useful hints for the better ordering of the universe."

It is hard to top that for smugness. Yet I must say that you are today "present at the creation" of a new direction in federal health policy and in the "ordering" of the way you deliver health and medical care in America. What is more, you even have the chance that was denied poor King Alfonso: you *can* give "some useful hints" and in other ways contribute to the public business being created.

I must confess that there is many a day when I wish I were back practicing surgery, directly involved in an immediate, palpable human problem and solving it. But then there is the challenge of taking part in the reshaping of health service in our society and knowing that, if it works, millions of Americans alive today and coming along in the days and years ahead may benefit.

It is an exhilarating feeling. I hope all of you may find a way to share in it.